Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-14-0207-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS IS NOT A DUPLICATE CLAIM/SERVICE. Have sent reconsiderations for these claims without any success on receiving full payment. Office visits are recommended as determined to be medically necessary."

Amount in Dispute: $143.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning charges on September 23, 2009 and October 24, 2012. Requestor filed it [sic] DWC-60 on September 20, 2013. The bills for September 23, 2009, were disputed as the bills were not submitted in timely manner. For these service dates the request for MRD review is also untimely… As to October 24, 2012, Carrier disputes that the Requestor is entitled to reimbursement for completion of a DWC-73 Work Status Report under CPT 99080. Per 28 TAC 129.6, a medical provider is entitled to reimbursement for completion of a DWC-73 only where that report is required by 28 TAC 129.6(d)."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2009	CPT Codes 99214 and 99080 – Filed to MFDR untimely	$128.35	$0.00
October 24, 2012	CPT Code 99080-73	$15.00	$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §129.5 sets out the procedures for filing Work Status Reports.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- W1 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
- 18 – Exact Duplicate Claim/Service

Issue

1. Did the requestor waive the right to medical fee dispute resolution?
2. Was the Work Status Report filed correctly?
3. Is the requestor due reimbursement for date of Service October 24, 2012?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the service in dispute is September 23, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 20, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for date of service September 23, 2009.
2. The respondent denied CPT Code 99080-73 for date of service October 24, 2012 using denial code 18 – "Exact Duplicate Claim/Service" and W1 – "Workers' Compensation Jurisdictional Fee Schedule Adjustment." Review of the submitted information finds insufficient documentation to support the denials; therefore, in accordance with 28 Texas Administrative Code §129.5(d), the doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions; and (3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee. Review of the Work Status Report for date of service October 24, 2012 finds that there were three changes in activity restrictions from date of service September 23, 2009 to October 24, 2012; the lift/carry restrictions changed from "May not lift/carry objects more than 5lbs for more than 10 hours per day" to "May not lift/carry objects more than 10lbs for more than 10 hours per day; Max hours per day of work was noted as 10 on September 23, 2009 on October 24, 2012 the max hours per day of work is listed as "3x/wk"; and the "Sit/Stretch breaks of "as per needed" on September 23, 2009, no sit/stretch breaks were noted on the October 24, 2012 DWC-73. Therefore change in activity restrictions was noted and reimbursement is recommended.
3. Therefore reimbursement in the amount of $15.00 is recommended for date of service October 24, 2012.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due for date of service October 24, 2012. As a result, the amount ordered is $15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 6, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.